SECTION 100. INTRODUCTION TO PRICE-BASED REIMBURSEMENT SYSTEM

A. Beginning January 1, 2000, a price-based reimbursement system will be implemented to reimburse a nursing facility (NF), a nursing facility with waiver (NF-W), a hospital based nursing facility (NF-HB) and a nursing facility with a mental retardation specialty (NF-MRS).

B. The price-base system is a reimbursement methodology based on a standard price set for a day of service as opposed to reimbursing facilities based on the latest submitted cost report. The standard price is based on reasonable, standardized wage rates, staffing ratios, benefits and absenteeism factors and "other cost" percentages.

C. A rate model was developed which resolves issues inherent in the current system reflects current reimbursement methodology trends and satisfies the needs of the Department and the Provider community. The goal of the price-based methodology was to develop a uniform, acuity adjusted rate structure that would pay a nursing facility the same reimbursement for the same type of resident served. This rate structure accounts for resource utilization and allows rates to increase annually by an appropriate inflationary factor. The rate model is market based and accounts for the higher wage rates urban facilities must pay their employees; therefore the urban average rate is slightly higher than the rural. The rate does not distinguish between hospital based and freestanding facilities.

D. This payment method is designed to achieve three major objectives:

1. To assure that needed nursing facility care is available for all eligible recipients including those with higher care needs; and,
2. To provide an equitable basis for both urban and rural facilities to participate in the Program; and,
3. To assure Program control and cost containment consistent with the public interest and the required level of care.

E. The system is designed to provide a reasonable reimbursement for providers serving the same type of resident in the nursing facility and to provide for a reasonable rate of return on the provider's investment.

F. This reimbursement methodology will not require the submission of a cost report in order to set prospective rates, but will utilize certain Medicaid schedules for the settlement of ancillary therapy cost and the Medicare

cost report for data. Except for the cost settlement of the ancillary portion of the facility's reimbursement, no year-end adjustment will be required.

G. The price-based model reimbursement methodology provides for a facility specific capital cost add-on calculated using the E.H. Boeckh System, a commercial valuation system that estimates the depreciated and non-depreciated replacement cost of a facility.

H. The Division of Licensing and Regulation has required the submission of the Minimum Data Set (MDS) since 1992 and DMS sought to use a tool familiar to the nursing facility industry in order to calculate case-mix. The case-mix portion of the rate will utilize the MDS 2.0 and the Resource Utilization Group (RUG) III to calculate the individual facility's average case-mix.

I. The case-mix portion of the rate will be adjusted quarterly to reflect the facility's most recent case-mix assessment and to adjust the direct care and non-personnel operation costs (supplies, etc.) portion of the standard price for the current quarter.

SECTION 110. PARTICIPATION REQUIREMENTS

A. The facilities referenced in Section one hundred (100) shall be reimbursed using the methodology described in 907 KAR 1:065. These facilities shall be licensed by the state survey agency (Office of Inspector General, Division of Licensing and Regulation) for the Commonwealth of Kentucky and certified for Medicaid participation by the Department for Medicaid Services.

B. A nursing facility, except a nursing facility with waiver, choosing to participate in the Medicaid Program will be required to have twenty (20) percent of its Medicaid certified beds participate in the Medicare program or ten (10) of its Medicaid certified beds participating in the Medicare program whichever is greater. If the NF has less than ten (10) beds all of its beds shall participate in the Medicare Program.

C. The Medicaid Program shall reimburse all Medicaid beds in a nursing facility at the same rate. The Medicaid rate established for a facility is the average rate for all Medicaid participating beds in that individual facility.

SECTION 120. PAYMENTS FOR SERVICES TO MEDICARE/MEDICAID RESIDENTS

A. Dually eligible residents and residents eligible for both Medicare and Medicaid (non-QMB) shall be required to EXHAUST any applicable benefits under Title XVIII (Part A and Part B) prior to coverage under the Medicaid Program.

B. APPLICATION. Services received by a resident that are reimbursable by Medicare shall be billed first to the Medicare Program. Any appropriate co-insurance or deductible payment due from the Medicaid Program shall be paid outside the Cost-based facility Cost-Related Payment System in a manner prescribed by the Department for Medicaid Services. Co-insurance and deductible payments shall be based on rates set by the Medicare Program. A day of service covered in this manner shall be considered a Medicare resident day and shall not be included as a Medicaid resident day in the facility cost report.

SECTION 130. PRICE-BASED NF REIMBURSEMENT METHODOLOGY

A. The price-based nursing facility reimbursement methodology reflects the differential in wages, property values and cost of doing business in rural and urban designated areas. This results in two standard rates, a standard rate reflecting the lower wages for the rural facilities and a slightly higher rate for the urban facilities.

B. The rural and urban designated areas are based on the "Metropolitan Statistical Area (MSA) designating the urban population centers based on the national census and updated on a yearly basis, as published by the Federal Office of Management and Budget.

C. In order to determine the standard rates for urban and rural facilities, the department utilized an analysis of fair-market pricing and historical cost for staffing ratios, wage rates, cost of administration, food, professional support, consultation, and non-personnel operating expenses as a percentage of total cost.

D. The standard price is comprised of the following components and percentages of the total rate:

1. Personnel 65%

2. Non-personnel operating 6%
3. Administration 13%
4. Food 4%
5. Professional supports & consultation 2%
6. Non-capital facility related cost 3%
7. Capital rate 7%

E. The standard price shall be re-based every four years and adjusted for inflation every July 1 using the Data Resource Incorporated (DRI) Healthcare Index.

F. A portion of the standard price for both urban and rural facilities will be adjusted each calendar quarter for "case-mix". The "case-mix" adjusted portion shall include the following:

1. The personnel cost of a:

   (a) DON-Director of Nursing;
   (b) RN-Registered Nurse;
   (c) LPN-Licensed Practical Nurse;
   (d) Nurse Aide;
   (e) Activities worker; and
   (f) Medical records director

2. The non-personnel operating cost including:

   (a) Medical supplies; and
   (b) Activity supplies

G. The "non-case-mix" portion of the standard price shall not be adjusted for case mix and includes:

1. Administration;
2. Non-direct care personnel;
3. Food;
4. Non-capital facility related costs;
5. Professional support;
6. Consultation; and,
7. Capital cost component.

H. The capital cost component shall be an "add-on" to the "non case-mix" adjusted portion of the rate. The capital cost component shall be adjusted each July 1 by the inflation factor found in the R. S. Means Construction Index.

I. Ancillaries are services for which a separate charge is submitted and includes:

1. Respiratory Therapy
2. Speech Therapy
3. Occupational Therapy
4. Physical Therapy
5. Oxygen Service
6. Laboratory
7. X-ray

J. Ancillary therapy services are reimbursed pursuant to 907 KAR 1:023.

K. Oxygen concentrator limitations. Effective October 1, 1991, the allowable cost of oxygen concentrator rentals shall be limited as follows:

1. A facility may assign a separate concentrator to any resident who has needed oxygen during the prior or current month and for whom there is a doctor's standing order for oxygen. For the charge by an outside supplier to be considered as an allowable cost, the charge shall be based upon actual usage. A minimum charge by an outside supplier is allowable if this charge does not exceed twenty-five (25) percent of the Medicare Part B maximum. The minimum charge is allowable if the concentrator is used less than an average of two (2) hours per day during the entire month (for example, less than 60 hours during a thirty (30) day month). The maximum allowable charge by the outside supplier shall not exceed one hundred (100) percent of the Medicare Part B maximum. For the maximum charge to a facility to be considered as the allowable cost, the concentrator shall have been used on average for a period of at least eight (8) hours per day for the entire month (for example, 240 hours during a thirty (30) day month). In those cases where the usage exceeds that necessary for the minimum charge and is less than the usage required for the maximum charge, the reimbursable shall be computed by dividing the hours of usage by

240 and then multiplying the result of this division by the Medicare Part B maximum charge. For example, if a concentrator is used less than 220 hours during a thirty (30) day month and the maximum Part B allowable charge is $250.00; then the allowable charge is computed by dividing the 220 hours by 240 hours and then multiplying the product of this division by $250.00 to obtain the allowable charge of $229.17. Allowable oxygen costs outlined in this paragraph shall be considered to be ancillary costs.

2. A facility shall be limited to one (1) standby oxygen concentrator for each nurses' station. The Medicaid Services Program may grant waivers of this limit. This expense shall be considered as a routine nursing expense for any month in which there is no actual use of the equipment. The allowable cost for standby oxygen concentrators shall be limited to twenty-five (25) percent of the maximum allowable payment under Medicare Part B for in home use.

NOTE: Effective October 1, 1990 drugs for residents in Cost-Based facilities shall be reimbursed through the pharmacy program.

L. Ancillary settlements will be made using the Medicaid cost report schedules and submitted within five (5) months of the provider's fiscal year end. The provider's billed charges for ancillary services will be retrospectively settled to the cost of ancillary services provided to Medicaid residents. This is accomplished by using the "ancillary cost-to-charge ratio" by dividing the total cost of ancillary services provided by a NF to its residents by the total customary and usual ancillary charges.

NOTE: Effective October 1, 1990 drugs for residents in Cost-Based facilities shall be reimbursed through the pharmacy program.

L. The department shall adjust the Standard Price if:

1. A government entity imposes a mandatory minimum wage or staffing ratio increase and the increase was not included in the DRI; or
2. A new licensure requirement or new interpretation of an existing requirement by the state survey agency that results in changes that affect all facilities within the class. The provider shall document

that a cost increase occurred as a result of licensure requirement or policy interpretation.

3. The provider shall submit any documentation required by the department.

SECTION 140. PRICE-BASED NF REIMBURSEMENT CALCULATION

A. For each calendar quarter, based on the classification of urban and rural, the department shall calculate an individual NF's price-based rate to be the sum of:

1. The case-mix adjustable portion of a NF Standard Price, adjusted by the individual NF's current average case-mix index. Except that until June 30, 2000 the average case-mix index shall be the greater of the current average case-mix index or the case-mix average calculated as a ratio of the facility's case-mix index to the statewide average case-mix index that would have been used for January 1, 2000 rate setting. After July 1, 2000 the individual NF's actual average case-mix shall be used in the rate calculation; and
2. The non-case mix adjustable portion of the assigned total Standard Price and the capital cost component.

B. A capital cost component shall be calculated on an individual facility basis based on the facility appraisal completed in November 1999. Re-appraisal shall be conducted and utilized every five years thereafter, effective with the July 1, 2004 rate setting. The Department shall contract with a certified appraisal company to perform the appraisal using the E.H. Boeckh Valuation System. The appraisal is based on the depreciated replacement value of the individual facility. The same Appraisal Company shall perform any re-appraisal that may be requested by a facility within that five-year period.

Effective with the rate setting period beginning July 1, 2000, the department shall utilize the R. S. Means Construction Index to adjust the capital cost component and the allowable per bed value for inflation.

C. A facility may request a re-appraisal within the five years should renovations or additions have a minimum total cost of $150,000 for facilities with more than sixty (60) licensed beds. For facilities having sixty (60) or less licensed beds, the total renovation or addition must be a

minimum total cost of $75,000. The individual NF shall submit written proof of construction cost to the department in order to request a re-appraisal. The individual NF shall reimburse the department's contracted appraisal company for the cost of the appraisal. The department shall reimburse the facility the cost of the appraisal or re-appraisal upon receipt of a valid copy of the paid invoice from the Appraisal Company.

D. A capital cost component shall be calculated on an individual facility basis. A capital cost component based on the results of the appraisal shall be the total of the average licensed bed value and ten (10) percent of the licensed bed value for land on which the NF is built. To this sum, add two thousand dollars per licensed bed for equipment. To determine the rate of return for capital cost, multiply the sum of the preceding paragraph by the yield on a thirty (30) year Treasury bond plus a risk factor of two (2) percent. The rate of return shall be no less than nine (9) percent or greater than twelve (12) percent per state fiscal year. The final calculation to determine the individual NF's capital cost component shall be the product of the rate of return calculation divided by the total number of NF bed days as calculated in paragraph D of this section.

E. To determine the average licensed bed value, the depreciated replacement cost of the NF shall be divided by the total number of licensed beds in the NF with the following limitations:

1. The average bed value shall not exceed $40,000; and
2. Shall exclude:

   (a) Equipment; and
   (b) Land

F. NF bed days used in the capital cost rate calculation shall be based on actual bed occupancy, except that the occupancy rate shall not be less than ninety (90) percent of certified bed days.

G. The department shall utilize a rate of return for capital costs that shall be equal to the yield on a thirty (30) year Treasury bond as of the first business day on or after May 31, 1999 and the first business day on or after May 31 thereafter. Should a change of ownership occur pursuant to 42 CFR 447.253 (2)(d), the new owner shall continue to receive the capital

cost rate of the previous owner unless the NF is eligible for re-appraisal pursuant to section IV B of this manual.

SECTION 150. ON-SITE REVIEWS AND VALIDATION

A. On a quarterly basis, beginning January 1, 2000 the department shall perform an on-site review of the NF. The review will consist of a minimum of ten (10) percent of the MDS assessments completed by the NF. The department shall validate the MDS assessments by using the Long Term Care Facility Resident Assessment Instrument User's Manual.

B. Should the department invalidate a NF's MDS, the NF may appeal the findings of the department within seven (7) business days. The department shall receive a written request by the NF that the department reconsider the invalidation. The department shall conduct the second validation with seven (7) business days of receipt of the request and notify the provider in writing of the decision. A provider may appeal the second validation per 907 KAR 1:671, Sections 8 and 9.

SECTION 160. LIMITATION ON CHARGES TO RESIDENTS.

A. Except for applicable deductible and coinsurance amounts, a NF that receives reimbursement for a Medicaid resident shall not charge a resident or his representative for the cost of routine or ancillary services.

B. A NF may charge a resident or his representative for an item if the resident requests the item and the NF informs the resident in writing that there will be a charge. A NF shall not charge a resident for an item or service if Medicare or Medicaid pays for the item pursuant to 42 CFR 483.10(c)(8)(ii).

C. A NF shall not require a resident or an interested party to request any item or services as a condition of admission or continued stay. A NF shall inform the resident or an interested party requesting an item or service that a charge will be made in writing that there will be a charge and the amount of the charge.

D. A NF may charge a resident for the cost of reserving a bed if requested by resident or interested party after the fourteenth (14^{th}) day of a temporary absence from the facility pursuant to 907 KAR 1:022.

E. Durable medical equipment (DME) and supplies shall be furnished by the NF and not be billed to the department under separate DME claim pursuant to 907 KAR 1:474.

SECTION 170. REIMBURSEMENT FOR REQUIRED SERVICES UNDER THE PRE-ADMISSION SCREENING RESIDENT REVIEW (PASRR).

A. Prior to admission of an individual, a price-based NF shall conduct a level I PASRR in accordance with 907 KAR 1:755, Section 4.

B. The department shall reimburse a NF for services delivered to an individual if the NF complies with the requirements of 907 KAR 1:755

C. Failure to comply with 907 KAR 1:755 may be grounds for termination of the NF's participation in the Medicaid Program.

SECTION 180. NF PROTECTION PERIOD AND BUDGET CONSTRAINTS

A. For the period of January 1, 2000 through June 30, 2002, a NF shall not receive a rate that is less than the rate that was set for the NF pursuant to 907 KAR 1:025E on July 1, 1999, including any capital cost and extenuating circumstance add-ons.

B. The department shall monitor payments on a monthly basis to ensure that aggregate payments made to NF's do not exceed the appropriated funds in fiscal years 2000 through 2002.

C. In order to monitor the payments, the department shall on a monthly basis notify the industry's representatives in writing the total payment amount for the preceding month.

D. The department shall also place on the Medicaid Internet site the amount of payment in aggregate to the NF's for the preceding month and the cumulative amount paid for the current state fiscal year.

E. For each year of the biennium, NF's shall receive an increase based on the DRI for the standard price and the R. S. Means Construction Index for the capital cost component. Except that a NF receiving less than the Standard Price shall have its rate adjusted for inflation July 1 of each year pursuant to the DRI. A NF shall receive no increase if the facilities rate is greater than the Standard Price including the capital rate component.

SECTION 190. ANCILLARY SERVICES

A. The reasonable, allowable and direct cost of an ancillary service, provided as a part of total care, shall be reimbursed by the department on a cost-basis and as an addition to the Standard Price.

B. A NF requesting that the department set an interim ancillary rate shall submit a request for a percentage factor that reflects the NF's cost-to-charge ratio and shall limit the percentage requested to no more than 100 percent of allowable cost.

C. In the event that the NF is underpaid for the total ancillary services provided to Medicaid eligible resident defined in the Medicaid supplemental schedules NF-4 and NF-6, the department shall increase the NF's cost-to-charge ratio to the nearest five (5) percent.

D. Should the NF be overpaid for the total ancillary services provided to Medicaid eligible residents as defined in the Medicaid supplemental schedules NF-4 and NF-6, the department shall proportionately decrease to the nearest five (5) percent the NF's cost-to-charge ratio up to a reduction of twenty-five (25) percent.

E. Ancillary services shall be subject to a year-end audit by the department, a retrospective adjustment and a final settlement.

F. In order to calculate a fiscal year end ancillary settlement, a NF shall include in its cost report the required schedules containing the actual ancillary service cost, the total ancillary charges, the total Medicaid charges and payments made by the department to the NF.

G. A NF shall submit documentation requested by the department in order to settle interim payments made by the department with cost of ancillary services provided for a NF's reporting period.

SECTION 200. REIMBURSEMENT REVIEW AND APPEAL

A NF may appeal department decisions as to the application of this regulation as it impacts the NF's price-based reimbursement rate in accordance with 907 KAR 1:671, Section 8 and 9.

SECTION 210. COST REPORT INSTRUCTIONS FOR PRICE-BASED

All Medicaid Supplemental Schedules must be accompanied by a working trial balance and audited financial statements (if applicable).

SECTION 1. SCHEDULE NF-1 – PROVIDER INFORMATION

Enter in the appropriate information. Choose whether the cost report is in a leap year or a regular 365 day year. Note that the cost report must have an original signature by an officer or administrator of the facility.

SECTION 2. SCHEDULE NF-2 – WAGE AND SALARY INFORMATION

This schedule records a facility's labor costs.

A. The pay period starting date should be the first day of the first payroll period in the provider's fiscal year. Likewise, the end date shall be the final day of the last payroll period in the fiscal year.

B. Under wage information, the hours paid includes vacation pay, sick leave, bereavement, shift differential and holidays in *addition to* time engaged in for regular business activity. Hours worked, in contrast, are only those hours that the employee spent at the facility in normal work duties. Wages paid should include all compensation paid to the employee, including time worked, time in training, vacation, and sick time.

C. Expenses incurred with outside businesses for temporary-nursing staff should be placed under contracted services. For each nursing category, enter the hours worked by the contract employees and the amount charged by the contracting business for wages paid. Hours paid and hours worked will differ only if the contract staff engaged in training while being employed at the facility.

D. Benefits paid by the facility for *all employees* (nursing staff, administrative, etc.) should be included under Section C: the facility's contribution for health insurance, life insurance, etc. would be listed under these categories.

SECTION 3. SCHEDULE NF-3 – STAFF INFORMATION

On an annual basis the Department for Medicaid Services shall select a seven-day period in which the facility records information regarding their staffing levels and patient days.

A. Record the number of residents in your facility in the Resident Census section. This includes *only* those full-time residents in the certified nursing facility section.

B. For each of the staff categories, record the number of staff on duty. Contract staff should be included in this category.

C. Continue this throughout the seven-day survey period.

SECTION 4. SCHEDULE NF-4 – ANCILLARY COSTS

Ancillary costs shall be entered on Schedule NF-4 for the purpose of performing a retrospective ancillary settlement. Instructions follow below on entering ancillary costs:

A. Column 2. Ancillary costs as shown in the provider's books shall be entered on the appropriate lines. All ancillary salaries shall be reported to the salaries lines and will automatically sub-total on the appropriate line.

B. Column 3. Reclassifications shall be detailed on Schedule NF-5 with an explanation accompanying each reclassification.

C. Column 4. Adjustments shall be detailed on Schedule NF-5 with an explanation accompanying each adjustment.

D. Column 5. The sum of Columns 2, 3, and 4 are totaled. The amount here is the facility's total ancillary cost.

E. Column 6. The cost entered to Column 5 shall be analyzed to identify the direct and indirect ancillary cost portions as defined in 907 KAR 1:065E. The direct ancillary cost shall be entered in Column 6. This amount should not be a negative amount.

F. Column 7. Indirect costs reports the indirect amounts entered in Column 5. Subtract Column 6 from Column 5 and enter the difference. This amount should not be a negative amount.

SECTION 5. SCHEDULE NF-5 – ADJUSTMENTS AND RECLASSIFICATIONS OF EXPENSES RECLASSIFICATIONS

A. Reclassification of expenses on Schedule NF-4 shall be entered here. Reclassifications can only be made within Schedule NF-4. A brief description shall be provided for each entry.

B. Adjustments
This schedule details the adjustments to the expenses listed on Schedules NF-4. Line descriptions indicate the nature of activities that affect allowable costs or that result in cost incurred for reasons other than patient care, and thus require adjustment. The adjusted amount entered in Schedule NF-5, column 2, shall be noted "A" when the adjustment is based on costs. When costs are not determinable, "B" shall be entered in column 2 to indicate that the revenue received for the service is the basis for the adjustment. Column 3 amounts must be entered as positive amounts for increases and negative amounts for decreases. A brief description shall be provided for each entry.

SECTION 6. SCHEDULE NF-6 – ANCILLARY SETTLEMENT

This schedule is designed to determine the Medicaid share of direct and indirect ancillary costs.

A. Column 2. The direct ancillary cost for each ancillary cost center automatically flows over from Schedule NF-4, column 6

B. Column 3. The direct costs (column 2) are multiplied by the corresponding Medicaid charge percentages (Schedule NF-7, Section A, Column 3, Lines 1 through 6).

C. Column 4. Enter the total amount received from the Department for Medicaid Services (including any amount receivable from the Department) for ancillary services rendered to KMAP CNF beneficiaries during the period covered by the cost report.

D. Column 5. The amounts in Column 5 are calculated by subtracting Column 3 from Column 4. The total on line 7 represents the balance due the Department or the amount due the facility.

SECTION 7. SCHEDULE NF-7 – ALLOCATION STATISTICS

A. Section A – Ancillary Charges

1. Column 1. Enter the total charges for each type of ancillary service on Lines 1 through 6. The sum of lines 1 through 6 are totaled on line 7.
2. Column 2. Enter the total charges for each type of ancillary service provided to KMAP patients in certified beds on lines 1 through 6. Lines 1 through 6 are summed and totaled on line 7.
3. Column 3. The Medicaid percentage in column 3 is calculated by dividing KMAP charges in column 2 by total charges in column 1. Percentages shall be carried to four decimal places (*i.e.*, XX.XXXX%).

B. Section B – Occupancy Statistics.
Certified Nursing Facility. Use the Bed Days Available worksheet in Box C to complete lines 1, 2, and 3. For line 4, enter in the Total Patient Days provided to all certified nursing facility residents. On line 6, enter in the KMAP Patient Days.

B. Non-Certified and Other Long-Term Care

1. Lines 1 and 2. Enter the number of licensed beds at the beginning and end of the fiscal year. Temporary changes due to alterations, painting, etc., do not affect bed capacity.
2. Line 3. Total licensed bed days available shall be determined by multiplying the number of beds in the period by the number of days in the period. Take into account increases and decreases in the number of licensed beds and the number of days elapsed since the changes. If actual bed days are greater than licensed bed days available, use actual bed days.
3. Line 4. Total patient days should be entered in.